Workforce Race Equality Standard (WRES) Trust Report 2022 & Action Plan for 2022-23

Pictured: **Sarah Wanjiku**: ENRICH lead and 2021-22 Developing Aspirant Leaders (DAL) participant for Staffordshire & Stoke-on-Trent ICS*

Date: **September 2022**

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Sherin Nassa, OD Practitioner (OD Talent Bank)

Lead Director: **Director of People, OD & Inclusion**

Front Cover profile*

Sarah Wanjiku
Senior Mental Health Practitioner, High Volume User Team
Trust ENRICH Network Lead
Graduate of the NHSEI Midlands Developing Aspirant BME Leaders Programme (2021-22)

Sarah has worked with the Trust since 2020 in the role of Senior Mental Health Practitioner in the High Volume User Team and has 7 years' nursing experience in the NHS. Sarah has recently concluded a high profile 12 months development experience on an NHS EI Midlands initiative, Developing Aspirant Black, Asian and Minority Ethnic Leaders Programme, throughout which she received sponsorship and mentoring by Kenny Laing, Executive Director of Nursing and Quality.

Sarah took on the lead role for our Trust Equality Network for Race Inclusion and Cultural Heritage (ENRICH) in April 2022 following the departure of our previous ENRICH lead, who moved on for career advancement to a role in Equality, Diversity and Inclusion in another Midlands Trust. Sarah takes on this role at a crucial time for Staff Networks being embedded and becoming more influential and impactful in 'how we do things' in our organisation and wider System.

Sarah said:

> *I am absolutely thrilled to take on this role at such a pivotal time. I am ambitious for us to really embed race inclusion throughout the Trust and for us to be one of the best employers for people of colour in the NHS. I will be working hard to see that we can achieve this in partnership with leadership and teams across the Trust. I will be linking in with our Executive Lead for the ENRICH Network, to keep them updated with the issues that members have been raising and to gain Board support in addressing the most challenging issues. I am also really looking forward to working with the other Trust staff network leads, so we can pool our efforts to make even greater gains for the benefit of staff all across the Trust.*
>
> *Being on the Aspirant Leaders programme has exposed me to experiences and people that otherwise I could not have known. I have learnt a lot about how things work and it has also helped me look at how I can develop in my future career. I have people internally and externally who I can ask for support. The course needs a lot of dedication, but people are available to support you including your sponsor. I am looking forward to supporting our system 2022-23 candidate on the programme.*

NSCHT Workforce Race Equality Standard (WRES) Report 2022

1. INTRODUCTION

The Workforce Race Equality Standard (WRES) was introduced in April 2015 and mandated as annual part of the NHS Standard Contract. Implementation of the WRES is a requirement on both NHS commissioners and NHS provider organisations.

The WRES is a key component in how the Trust works to deliver tangible and lasting improvement on race inclusion, also supporting how as an organisation we deliver on our obligations under the Public Sector Equality Duty (PSED) to:

i. **Eliminate unlawful discrimination**, harassment and victimisation and other conduct prohibited by the Act.
ii. **Advance equality of opportunity** between people who share a protected characteristic and those who do not.
iii. **Foster good relations** between people who share a protected characteristic and those who do not.

The WRES ultimately supports the Trust to increase diversity and inclusion, enabling us to deliver services for all people within our communities. Put frankly, it is not possible to deliver safe, personalised, accessible and recovery-focussed services if we are not diverse and inclusive as an employer.

This 2022 report contains the Trust's seventh annual WRES performance and our associated action plan. This will be published on our website and shared with NHS England and our local commissioners, as well as being reviewed as part of any CQC inspection processes as may be required.

The key purposes of the WRES are to:

- '**hold a mirror up to the NHS** and **spur action** to close gaps in (established and persistent) workplace inequalities between our black and minority ethnic (BME) and white staff'
- **prompt inquiry** and assist organisations to **develop and implement evidence-based responses** to the challenges their data reveal
- complement national NHS workforce policy on diversity and inclusion, and support delivery of national policy frameworks, recently including **delivering the NHS People Plan**.

1.2 WRES Reporting Requirements

Trusts are required to submit and publish the WRES annually as part of the NHS Standard Contract. Requirements for 2022 are in two stages, as below:

1. **Submit 2022 Trust WRES Dataset** to NHS England via the DCF by 31 August 2022

2. **Publish and share this WRES progress report and action plan** by 31 October 2022 (including sharing the document on our Trust website and sending it to local commissioners)

1.3 Notes on language and terminology

As with other areas of inclusion, the language of race inclusion is powerfully meaning- and value-loaded. It is much-debated, continually changing and can be highly emotive. **No single term suits or is preferred by all individuals that it seeks to represent, nor every situation.** It is clear that our diverse ethnic local communities and Trust workforce are themselves highly diverse, being formed from a wide variety of national / international / continental backgrounds and ancestry/ heritage (potentially mixed many times over), varied religious beliefs (or none) and cultures, and other cultural groups and influences. Groups will both share and differ from other groups (and within groups) in relation to their experiences, their motivations, their wants and needs. It is therefore important to note that, whilst in this WRES Report we are looking at the experiences of our ethnic diverse heritage colleagues compared to that of white colleagues, **neither of these groups is a homogenous group**. From an **intersectional perspective**, it is also important to note that groups referred to within this report will also have other varied identities, including different genders and gender identities, different sexual orientations, different ages, religions and other characteristics.

- **Race descriptors / Describing groups of people with ethnic diverse heritage**

Race terminology has been extensively debated at a national level during 2020-21 resulting in NHS Race Observatory guidance being issued in November 2022 (following a national consultation exercise) recommending avoidance of the use of acronyms in relation to race identities.

In response to this, the terms '**People of Colour'**, '**diverse ethnic heritage' and 'Black Asian and Minority Ethnic'** (in full) are used interchangeably through the narrative of this report, following the decision as a Trust in early 2022 to avoid the use of acronyms to describe people's ethnic heritage whenever possible. The acronym "BME", representing **Black and Minority Ethnic,** is however used frequently throughout this report, and particularly when referencing charts and figures, as this remains the term used by the WRES team, having been used since the inception of the WRES in 2015.

- **WRES Aspirational Targets**

In addition to the usual annual WRES process and national annual report, late in 2019, the WRES Team issued each Trust with a bespoke set of 'aspirational targets' for year-on-year improvement in the BME representation in senior posts (band 8A and above). These targets seek to attain a minimum of 7.6% (local BME population in 2011 census) in each senior band/grade by end of March 2028. The trust will revise these targets when the 2021 census data is released. Progress with these aspirational targets would form part of the appraisal of every Trust CEO from 2020-21 onwards.

- **Race Disparity Ratio**

Introduced in 2021, supplementing the WRES Aspirational Targets. The Race Disparity Ration considers NHS pay groups (bands) – medical excluded - and assesses whether diverse ethnic representation is equitable in 3 different 'clusters' (Bands 1-5 form cluster 1, Band 6 and 7 form cluster 2 and Band 8a plus form cluster 3). It seeks to measure the probability of white staff versus BME staff being promoted through the lower, middle and higher bands.

- **Workforce Race, Equality and Inclusion Strategy**

Launched in early 2021 to supplement the WRES process and accelerate progress in the Midlands NHS regions. Specifically requires Trusts and systems to develop and deliver against a 'High Impact Action Plan on Recruitment' as a key means to delivering BME inclusion.

- **Equality Network for Race Inclusion and Cultural Heritage – 'ENRICH'**

The name of our ethnic diverse staff network since 2021.

1.4 Key Concepts

- **Black and Minority Ethnic / BME:** Several terms are used in public policy, and in wider society, to refer to collective ethnic minority populations. These include Black, Asian and Minority ethnic (BAME), and black minority ethnic (BME), people of colour, and racialised minorities. For the purpose of this strategy we have used the term BME to describe groups of people whose ethnicity or racial background is a key factor in their experience or risk of racial discrimination at work in the NHS. This is not an endorsement of this term into the future, but an effort to ensure consistency with other NHS workforce race equality publications.

- **Racism:** Racism is often misunderstood as just treating someone unfairly or holding prejudiced views. Prejudice views and unfair treatment can occur between any racial groups. However, there is a much more fundamental issue. Systemic racism is power and privilege that can offer intrinsic advantages to White people over people from a Black, Asian and minority ethnic background.

- **Institutional Racism**: The Macpherson report's definition of institutional racism is "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people"

- **Structural Racism**: inequality rooted across the operation of a system or society that excludes and/or has a significant negative impact on large numbers of a particular racial group and their ability to participate.

- **Discrimination**: Discrimination happens when someone is treated unfairly or less favourably due to an actual or perceived protected characteristic and is unlawful under the Equality Act 2010.

  There are four types of discrimination. Examples given are in the race context:

  1. **Direct discrimination** – Treating someone worse than someone else, for example not inviting someone for an interview because you believe them to be from a particular racial background
  2. **Indirect discrimination** – Rules, policies, or ways of doing things which have a worse impact on someone with a particular characteristic than someone from another group, for example Friday team meetings taking place in a pub.
  3. **Harassment** – violating someone's dignity; creating a hostile, humiliating, degrading or offensive environment. For example, making fun of someone's name or how it is pronounced.
  4. **Victimisation** – This is treating someone unfairly if they are taking action under the Equality Act or supporting someone else who is doing so. For example, a white ally can be victimised if they are supporting a BME colleague with a harassment claim.

- **White Privilege:** Coined by the black civil rights activist William Du Bois in the 1930s and later coming to further prominence in Peggy McIntosh's 1988 ground breaking paper White Privilege: Unpacking the invisible knapsack, the term white privilege is used to describe how having white skin gives an individual an advantage in life. White privilege does not mean that white people have never struggled, but in Britain they do not experience racial discrimination on an institutional or societal basis.

  Having white privilege and recognising it is not racist. But white privilege exists because of historic, enduring racism and biases and is the "power of accumulated power"

2.0 PERFORMANCE AGAINST THE 9 WRES INDICATORS

Indicator 1: Workforce profile: Trust Ethic Diverse Heritage Workforce Representation

Band / Pay group	White	BME		Un-known	TOTAL WF 2022	White	BME		2022 BME Difference from 9.1% (overall BME WF)
	Head-count 2022	Head-count 2022	(Head-count 2021)	Head-Count 2022	Total	% 2022	% 2022	(% 2021)	% diff 2022
< Band 1	17	**2**	1	1	20	85.0%	**10.0%**	6.7%	**0.9%**
Band 1	3	**0**	0	0	3	100.0%	**0.0%**	0.0%	**-9.1%**
Band 2	100	**6**	6	1	107	93.5%	**5.6%**	5.7%	**-3.5%**
Band 3	350	**30**	25	18	398	87.9%	**7.5%**	6.8%	**-1.6%**
Band 4	132	**9**	6	2	143	92.3%	**6.3%**	4.3%	**-2.8%**
Band 5	191	**28**	30	5	224	85.3%	**12.5%**	12.8%	**3.4%**
Band 6	364	**24**	15	2	390	93.3%	**6.2%**	4.2%	**-2.9%**
Band 7	210	**15**	12	1	226	92.9%	**6.6%**	6.2%	**-2.5%**
Band 8a	90	**3**	5	2	95	94.7%	**3.2%**	6.3%	**-5.9%**
Band 8B	34	**2**	1	0	36	94.4%	**5.6%**	2.8%	**-3.5%**
Band 8C	21	**1**	0	1	23	91.3%	**4.3%**	0.0%	**-4.8%**
Band 8D	8	**0**	0	0	8	100.0%	**0.0%**	0.0%	**-9.1%**
Band 9	1	**0**	0	0	1	100.0%	**0.0%**	0.0%	**-9.1%**
VSM*	5	**3**	2	0	8	62.5%	37.5%	0.0%	**10.9%**
Medical	23	**38**	33	4	65	35.4%	**58.5%**	0.0%	**49.4%**
Other (TUPE)	22	**0**	0	3	25	88.0%	**0.0%**	5.7%	**-9.1%**
Grand Total*	**1,571**	**161**	136	40	**1772**	**88.7%**	**9.1%**	(8.2%)	**0.0%**

Table 1: Workforce Race Breakdown:
Headcount and percentages (whole workforce) as at 31.03.22 (31.03.21 in grey)
*excludes 7 non-executive positions (not counted in standard ESR reporting data)

Cluster	Bandings Grouped	White Headcount 2022	BME Headcount 2022 (2021 in brackets)	Unknown head-count 2022	White % 2022	BME % 2022	Unknown % 2022
1	**1 to 5**	793	**75** (67)	27	88.6%	**8.4%**	3.0%
2	**6 and 7**	574	**39** (27)	3	93.2%	**6.3%**	0.5%
3	**Band 8a+ (exclg medical and other)**	159	**9** (8)	3	93.0%	**5.3%**	1.8%
Grand Total* (excluding medical & 'Other')		**1,526**	**123** (102)	33	**90.7%**	**7.3%**	**2.0%**

Table 2: 'Cluster' Groupings – headcount and percentages 2022

	2022	(2021)
Disparity ratio - lower to middle	**1.39**	**1.64**
Disparity ratio - middle to upper	**1.20**	**0.82**
Disparity ratio - lower to upper	**1.67**	**1.33**

Table 3: Race Disparity Ratios for the 3 'Clusters' 2022 (2021 in brackets)

Trust Non-Clinical and Clinical Workforce as at 31 March 2022 (headcount and percentages)

Headcount

non clinical 2022	White	BME	Unknown	TOTAL
under bd 1	0	0	0	**0**
bd 1	3	0	0	**3**
bd 2	82	5	1	**88**
bd 3	95	4	9	**108**
bd 4	52	4	1	**57**
bd 5	38	1	1	**40**
bd 6	28	1	0	**29**
bd 7	22	1	0	**23**
bd 8A	18	0	0	**18**
bd 8B	13	0	0	**13**
bd 8C	6	0	0	**6**
bd 8D	5	0	0	**5**
bd 9	1	0	0	**1**
VSM	4	2	0	**6**
TOTAL NON-CLIN	**367**	**18**	**12**	**397**

Table 4

clinical 2022	White	BME	Unknown	TOTAL
under bd 1	17	2	1	**20**
bd 1	0	0	0	**0**
bd 2	18	1	0	**19**
bd 3	255	26	9	**290**
bd 4	80	5	1	**86**
bd 5	153	27	4	**184**
bd 6	336	23	2	**361**
bd 7	188	14	1	**203**
bd 8A	72	3	2	**77**
bd 8B	21	2	0	**23**
bd 8C	15	1	1	**17**
bd 8D	3	0	0	**3**
bd 9	0	0	0	**0**
VSM	1	1	0	**2**
Medical	23	38	4	**65**
TOTAL CLINICAL	**1182**	**143**	**25**	**1350**

Table 5

Other 2022	White	BME	Unknown	TOTAL
other	22	0	3	**25**

Table 6

	White	BME	Unkown	TOTAL
Grand total	**1571**	**161**	**40**	**1772**

Table 7

Percentages

non clinical 2022	White	BME	Unknown	TOTAL
under bd 1	0.0%	**0.0%**	0.0%	0.0%
bd 1	100.0%	**0.0%**	0.0%	100.0%
bd 2	93.2%	**5.7%**	1.1%	100.0%
bd 3	88.0%	**3.7%**	8.3%	100.0%
bd 4	91.2%	**7.0%**	1.8%	100.0%
bd 5	95.0%	**2.5%**	2.5%	100.0%
bd 6	96.6%	**3.4%**	0.0%	100.0%
bd 7	95.7%	**4.3%**	0.0%	100.0%
bd 8A	100.0%	**0.0%**	0.0%	100.0%
bd 8B	100.0%	**0.0%**	0.0%	100.0%
bd 8C	100.0%	**0.0%**	0.0%	100.0%
bd 8D	100.0%	**0.0%**	0.0%	100.0%
bd 9	100.0%	**0.0%**	0.0%	100.0%
VSM	66.7%	**33.3%**	0.0%	100.0%
TOTAL NON-CLIN	**31.0%**	**4.5%**	**3.0%**	**38.6%**

Table 8

clinical 2022	White	BME	Unknown	TOTAL
under bd 1	85.0%	**10.0%**	5.0%	**100.0%**
bd 1	0.0%	**0.0%**	0.0%	**0.0%**
bd 2	94.7%	**5.3%**	0.0%	**100.0%**
bd 3	87.9%	**9.0%**	3.1%	**100.0%**
bd 4	93.0%	**5.8%**	1.2%	**100.0%**
bd 5	83.2%	**14.7%**	2.2%	**100.0%**
bd 6	93.1%	**6.4%**	0.6%	**100.0%**
bd 7	92.6%	**6.9%**	0.5%	**100.0%**
bd 8A	93.5%	**3.9%**	2.6%	**100.0%**
bd 8B	91.3%	**8.7%**	0.0%	**100.0%**
bd 8C	88.2%	**5.9%**	5.9%	**100.0%**
bd 8D	100.0%	**0.0%**	0.0%	**100.0%**
bd 9	0.0%	**0.0%**	0.0%	**0.0%**
VSM	50.0%	**50.0%**	0.0%	**100.0%**
Medical	35.4%	**58.5%**	6.2%	**100.0%**
TOTAL CLINICAL	**87.6%**	**10.6%**	**1.9%**	**100.0%**

Table 9

Other 2022	White	BME	Unknown	TOTAL
other	88.0%	0.0%	12.0%	**100%**

Table 10

	White	BME	Unkown	TOTAL
Grand total	**88.7%**	**9.1%**	**2.3%**	**100%**

Table 11

At NSCHT, our aim is to be representative of our overall ethnic diverse workforce (9.1% as at 31.3.22) through <u>all</u> bands (clinical and non-clinical) AND to exceed the (conservative) 7.6% ethnic diverse population estimate (based on 2011 census) after medical staff are excluded.

[Note: Data from the 2021 census is due to be published by December 2022, and it is predicted that this will show significant growth in the local BME population since 2011.]

The trend of a growing Trust ethnic diverse workforce continues with an overall rate of **9.1%** (up from 8.2% in 2021) and a headcount of 161. This is our **highest rate** (and headcount) and **biggest increase** to date. This percentage also exceeds the 7.6% local ethnic diverse population as a whole.

The corresponding figure **after medical staff are excluded is 7.2%.** Unfortunately this figure remains short of local population estimate (based on the 2011 census). The shortfall is likely to be greater when the 2021 census data becomes available for the local area.

A very significant **58.5%** of our Trust **medical workforce** are of ethnic diverse heritage.

Our **non-clinical workforce** significantly lags behind our clinical workforce in terms of both our local population and our Trust overall ethnic diverse representation.

- Non-Clinical Trust Ethnic Diverse Workforce: 4.5%
- Clinical Trust Ethnic Diverse Workforce: 10.6% (8.2% when excluding medical)

It is noted that our non-clinical representation consistently under-represents for ethnic diverse colleagues in ALL LEVELS / BANDS (except for VSM). **This position is unacceptable and a priority for action in 2022-23 and the next few years.**

For **clinical** workforce, the picture is the same, except for band 5 (predominantly made up of staff nurses, accounting for 27 ethnic diverse colleagues) and (less than band 1) apprenticeships (of which 2 individuals have ethnic diverse heritage).

The national 2021 WRES reports that the NHS has an overall BME workforce of 22.4%, which is much higher than the Trust rate, but this is largely on account of our much lower ethnic diverse population for the Trust's local footprint, therefore direct comparisons to the national rate are inappropriate.

NHS England additionally group the different bands into 3 'Clusters' analysis and comparison purposes. These clusters are presented in three tiers as illustrated in Table 12 below –

Cluster	Bandings	Non-Clinical BME %	Clinical BME %	Overall BME %
Cluster 1 'lower'	<1 to 5	4.7%	10.2%	8.4%
Cluster 2 'middle'	6 and 7	3.8%	6.6%	6.3%
Cluster 3 'upper'	Band 8a+	4.1%	5.7%	4.7%
Total WF	(exclg medical and 'other')	4.5%	8.2%	7.2%

Table 12: Trust ethnic diverse representation by Cluster group

For all groups except Cluster 1 (Clinical), it is evident that there is an **under-representation of ethnic diverse colleagues**. It therefore remains important to focus on the development of

progression of ethnic diverse staff in lower bands, in order to deliver a more diverse future workforce at band 6 and above.

WRES Aspirational Targets

It is well-documented that the NHS under-represents for ethnic diverse heritage colleagues, particularly in more senior bands (medical and dental workforce being the exception). The national WRES reports states that Trusts must do more to improve their talent pipeline if they are to achieve the model employer ambitions. The **WRES Aspirational Target** nationally for BME representation is 19% across all pay grades, including band 8A+. For Combined Healthcare, this currently translates to 7.3% as the Trust's ethnic diverse workforce percentage (with medical staff, VSM and 'other' staff excluded). Trusts are mandated with closing the gap in bands 8A and above by 2028.

We have set the target of 9.1% (our overall Trust ethnic diverse workforce) for the purpose of outlining our WRES aspirational targets and how many people this translates to, as set out below.

	white	BME	unknown	total			white	BME	unknown	Difference of BME % from 9.1%	BME Headcount if proportionate to 9.1% (rounded to nearest 1)	Number of BME appointments required to be equitable: ie 'WRES Aspirational Target'
Band 8a	90	3	2	95		**Band 8a**	94.7%	3.2%	2.1%	-5.9%	9	6
Band 8B	34	2	0	36		**Band 8B**	94.4%	5.6%	0.0%	-3.5%	3	1
Band 8C	21	1	1	23		**Band 8C**	91.3%	4.3%	4.3%	-4.8%	2	1
Band 8D	8	0	0	8		**Band 8D**	100.0%	0.0%	0.0%	-9.1%	1	1
Band 9	1	0	0	1		**Band 9**	100.0%	0.0%	0.0%	-9.1%	0	0
VSM	5	3	0	8		**VSM**	62.5%	37.5%	0.0%	+28.4%	N/A	
										TOTAL APPOINTMENTS REQD.		9

Table 13

To achieve our WRES Aspirational Targets by 2028, the Trust needs to progress and/or appoint 9 ethnic diverse individuals into Band 8 roles, as illustrated in Table 12 above (based on current Trust establishment).

Race Disparity Ratios

Our Race Disparity Ratios (RDR) provide a measure intended to reflect the progression of ethnic diverse staff from lower to higher levels in the workforce, by comparing BME representation amongst a lower set of pay bands with BME representation at a higher set of pay bands.

- A value of "1.0" indicates equity in representation at higher and lower levels
- A value greater than "1.0" indicates that BME staff are underrepresented at the higher pay bands, and
- A value below "1.0" indicates BME staff are overrepresented at the higher pay bands.

[Mathematically, each RDR is an odds ratio that divides the odds of White staff being at the higher level compared to the lower level by the odds of BME staff being at the higher level compared to the lower level; the statistical significance of any deviation from a value of "1.0" is assessed using the 95% confidence interval for the odds ratio. Further explanation on the calculation of this metric is available from the WRES team.]

	Trust Non-Clinical WF Race Disparity Ratio	Trust Clinical WF Race Disparity Ratio	Overall Trust WF Race Disparity Ratio
Disparity ratio – lower to middle	**1.30**	**1.65**	**1.39**
Disparity ratio – middle to upper	**0.94**	**1.13**	**1.35**
Disparity ratio – lower to upper	**1.22**	**1.87**	**1.88**
Average Trust Race Disparity Ratio:			**1.54**

Table 14: Trust Race Disparity Ratios as at 31 March 2022
(**Green**: RDR <1.25; **Amber**: RDR of 1.25:2.50; **Red**: RDR >2.50)

From data in Table 14, it can be concluded that the Trust over-represents in the higher bands when comparing middle to upper bandings for non-clinical staff.

For all other Race Disparity Ratio comparisons, the Trust under-represents (clinical and non-clinical staff) when comparing lower to higher bands.

Figures for the ICS, Midlands region and National average are provided below for comparison purposes (based on 2020 WRES data):-

	Staffs & SOT ICS average RDR (2021)	Midlands Region RDR (2021)	National Average RDR (2021)
RDR lower to middle	**1.40**	**1.29**	**1.39**
RDR middle to upper	**1.17**	**1.97**	**1.83**
RDR lower to upper	**1.70**	**1.57**	**1.61**

Table 15: 2021 Average RDR data for ICS, Midlands Region and National (RAG rating as above)

Our Trust RDRs for 2021 are broadly in line with the national and local picture in 2021. However, it is our aim to see our RDR reducing to ratios of below 1.25 over the next 1-2 years.

Indicator 2:

Recruitment: relative likelihood of BME applicants being appointed from shortlisting across all posts compared to white applicants

[*Note: Overseas application data has been removed from figures as ineligible for work in the UK, therefore ineligible for shortlisting.]

Our 2021-22 recruitment data is detailed in the tables below and chart over-page:-

Trust WRES recruitment data by ethnicity APRIL 2021 - MARCH 2022	Applications	Shortlisted*	Offers made*
White - all white backgrounds	**2683** (5878)	**969** (1467)	**496** (391)
Black, Asian & Minority Ethnic (including mixed heritage)	**943** (1646)	**249** (322)	**100** (66)
Not known / Not stated	**45** (153)	**15** (34)	**3** (6)
TOTAL	**3671** (7677)	**1233** (1823)	**599** (463)

Trust WRES recruitment data APRIL 2021 - MARCH 2022	Applications %	Shortlisted* %	Offers Made* %
White - all white backgrounds	**73.1%** (76.6%)	**78.6%** (78.6%)	**82.8%** (82.8%)
Black, Asian & Minority Ethnic (including mixed heritage)	**25.7%** (21.4%)	**20.2%** (17.7%)	**16.7%** (14.3%)
Not known	**1.2%** (2.0%)	**1.2%** (1.9%)	**0.5%** (1.3%)

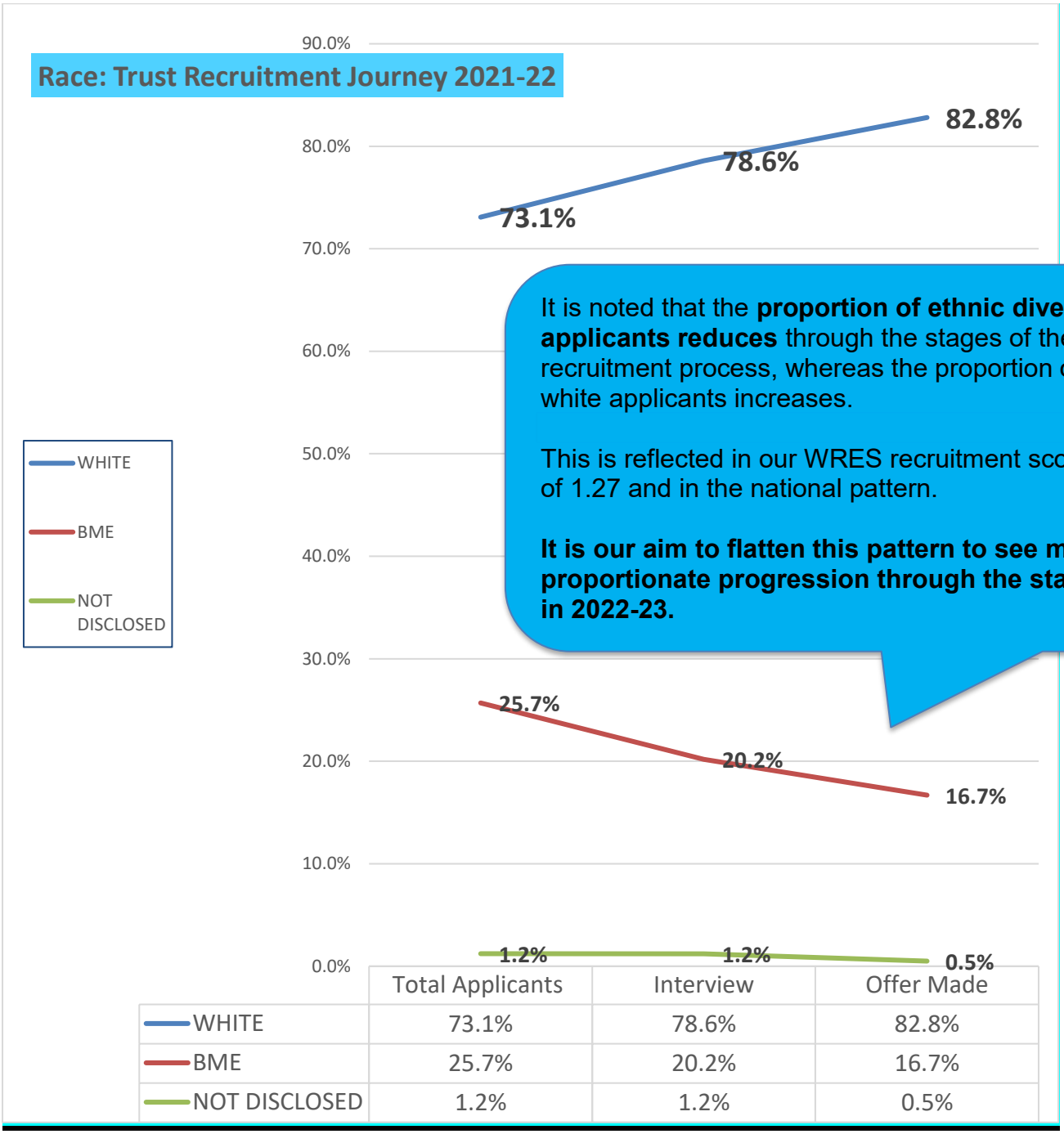
Table 16 Trust Recruitment Data by Ethnicity 2021-22 (2020-21 in brackets)
***Note the WRES recruitment score is based on Shortlisted and Offered data only.*
Source: Trust recruitment data 1st April 2021-31st March 2022 (2020-21 in brackets)

WRES Recruitment Score 2022: 1.27 (1.30 in 2021)

Indicator 2		2016	2017	2018	2019	2020	2021	2022
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	National WRES report	1.57	1.60	1.45	1.46	1.61	**1.61**	*Published in Feb 2023*
	NSCHT performance	**2.66** ***Worse than average***	**1.20** ***Better than average***	**1.96** ***Worse than average***	**2.07** ***Worse than average***	**1.89** ***Worse than average***	**1.30**	**1.27**

Continued improvement: Much better than national position but aiming for closer to 1.00

Table 17 *WRES recruitment scores 2016 – 2022 (Trust scores compared with national average)*
[a score of one would mean equal access to recruitment appointments]



	Total Applicants	Interview	Offer Made
WHITE	73.1%	78.6%	82.8%
BME	25.7%	20.2%	16.7%
NOT DISCLOSED	1.2%	1.2%	0.5%

Figure 18: Ethnicity and Trust Recruitment 2021-22

The relative likelihood of ethnic diverse staff being appointed compared to white staff in 2021-2022 is 1.27, representing a significant and continued improvement from 1.30 in 2021 and 1.89 in 2020. However a score of 1.0 would equate to 'equality of opportunity' and we have some way to go to achieve this. [Note: a score of 1.0 means equal likelihood of being appointment from shortlisting for both white and ethnically diverse origin (i.e. a score of < 1 positively skewed in favour of ethnically diverse heritage, a score of >1 is positively skewed in favour of white heritage).]

The 2022 WRES national likelihood figure will not be published until February 2023. However, when compared with the national figure for 2021 (national average score of 1.61), our performance is 0.31 better than nationally for that year. This year's score of 1.27 is therefore expected to be significantly better than average nationally and likely in the top quartile when the 2022 national report is published (in Spring 2023).

The chart above illustrates that BME applicants are still disadvantaged through the successive stages of our recruitment process, as seen by the increasing proportion of white applicants at each stage in comparison to the declining proportion of BME and 'ethnicity not known' applicants.

It is recognised nationally and regionally that Trusts need to substantially improve performance on this measure to bring about more equitable BME inclusion in the NHS. As such, the Midlands workforce race, equality and inclusion strategy (WREI) was launched in early 2021 requiring Trusts and systems to develop detailed high impact plans in this area. The Trust has been working with system colleagues to develop this action plan (available on request) and performance against this will be closely monitored over the coming years locally, regionally and nationally.

This indicator continues to be a priority for the Trust to further improve on our performance on this important measure. We aim for a Recruitment Score close to 1.00 in the first instance. However, it is noted that in order to accelerate change through the workforce structure (all bands and all staff groups, clinical and non-clinical), a score of less than 1.00 is desirable for a period. The Trust will continue to improve the equity in recruitment and selection between white applicants and people of colour.

Our Trust approach to Inclusive recruitment has seen the following in 2021-22:-

- Assessment centres now in place for Band 5 Registered posts, HCSW and apprenticeships, in continuation of the batch recruitment approach for apprenticeships band 3 healthcare support workers and band 5 nurses
- Advertising campaign created with inclusive imagery and wording with Nursing Times and BMJ
- Discussions with staff network groups for inclusive recruitment material
- Building on success of Nursing Times event and contacting areas outside of Staffordshire to encourage applications with relocation packages
- Offering flexible shift patterns to attract wider range of applicants
- International Nursing Recruitment commencing in partnership with MPFT with an inclusion focus
- Values Based Development group commenced to look at recruitment
- Diverse interview and assessment panels for all Band 7 and above interviews, and for all assessment centre panels (encouraged for posts at all levels)
- Collaborative development of more inclusive R&S processes with system colleagues
- Positive action recruitment and support for our ethnic diverse nursing and AHP students and preceptees. We are working to improve monitoring of the retention and career journey of these individuals
- Positive action approaches to advertising vacancies, included greater use of diverse workforce images and wording encouraging applications from under-served/under-represented groups through large scale promotional campaigning.

Indicator 3 – Disciplinary Measure

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff

Disciplinary data for the last two years is illustrated in table 19 below.

	Disciplinary cases 2021-2022	Disciplinary cases 2020-2021
White	7	2
BME	0	1
Ethnicity not known/ not stated	1	0
TOTAL CASES IN YEAR	**8**	**3**

Table 19

Table 20 below details year-on-year performance figures on this measure compared to the national position:-

Indicator		2016	2017	2018	2019	2020	2021	2022
3. Relative likelihood of BME staff entering formal disciplinary process compared to white staff.	National WRES report	1.56	1.37	1.24	1.22	1.16	1.14	**Published Feb 2023**
	NSCHT performance	2.28 *Worse than average*	1.77 *Worse than average*	10.52 (outlier) *Much worse than average*	0.88 *Better than average*	1.39* *Worse than aver-age*	**4.35** ***Much worse than aver-age***	**0.0** **No cases involving BME staff in 2022**

Table 20 **Note: This figure has been recalculated based on recent information and updated national guidance. [a score of one would mean equal access to development opportunities]*

As there were no disciplinary cases involving ethnic diverse colleagues in 2021-22, our **disciplinary measure score is 0.00.** This compares **very favourably** to our Trust score of 4.35 in 2020-21 (not statistically significant).

It is noted that the Trust has been working to drastically reduce the number of disciplinary cases by applying much greater rigour in the early stages when an incident arises, using the Restorative Just & Learning Culture Framework approach. This change (in part) has resulted in the very low number of disciplinaries in 2020/21 (8 in total, and just 3 in the previous year). However, with such small numbers of disciplinary cases and a BME workforce of 9.1% it is likely that even a small number of BME cases (even just one) can result in a BME over representation and a negatively ranked score on this message.

This indicator remains a key challenge for the Trust. However, with further embedding of the Trust's approach and use of the Restorative Just and Learning Culture framework checklist, we are confident that disciplinary investigations are only being applied when absolutely necessary and appropriate rigour has been adopted to help eliminate effects of any potential bias that may be present.

Indicator 4:

Training Measure: Relative likelihood of BME colleagues accessing non-mandatory training compared to white colleagues

Indicator		2016	2017	2018	2019	2020	2021	2022
4. Relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff.	National WRES report	1.11	1.22	1.15	1.15	1.14	*1.14*	***Published Feb 2023***
	NSCHT performance	**1.13** ***Approx same as average***	**0.76** ***Better than average***	**0.95** ***Better than average***	**0.68** ***Better than average***	**0.78** ***Better than average***	**0.67** ***Better than average***	**0.47**

Further Improvement Made
Consider that further improvement is required when doctors excluded

Table 21

This indicator assesses the proportion of BME staff accessing AT LEAST ONE piece of NON-MANDATORY development, in comparison to the proportion of white staff accessing the same.

Historically, the Trust has *ostensibly* performed well on this measure, with a score in favour of BME staff, and the 2021 score is no exception to this trend. However, deeper analysis reveals that there ***IS*** actually a negative likelihood of accessing development for BME staff when medical staff are excluded from the data. The high proportion of BME doctors in the Trust 58%) is partly responsible for the positive skewing of the Trust's scores on this measure over the years.

In 2021-22:

- The balance of this measure was again in favour of BME staff, with a score of **0.47** (compared to 0.67 in the 2021 WRES).
- Overall, ethnic diverse staff were **much more likely** to access at least one piece of non-mandatory development than white staff.
- 22.4% of white staff compared to 47.8% of ethnic diverse staff had undertaken non-mandatory development activity.

When medical staff are removed from the data, the balance changes in favour of white staff to a score of **1.38** (1.67 in 2021 and 2.10 in 2020) [where a score of one means equal access to development opportunities]. With medics excluded: 20.7% of white staff had completed at least one piece of non-mandatory training, compared to 19.9% of ethnic diverse staff – reflecting a more equal picture but one slightly skewed in favour of white staff.

So, despite the above ostensible position in our WRES reporting on Metric 4, the Trust needs to continue to work to ensure that ethnic diverse colleagues gain equal access to development opportunities compared to their white counterparts.

The Trust D&I Lead continues to communicate information on development opportunities directly to ethnic diverse colleagues to support access for this group, bypassing the need for line management sharing.

[Note: No analysis was undertaken with regard to the length / type of development programmes (eg a year-long programme counts the same as a half-day session)].

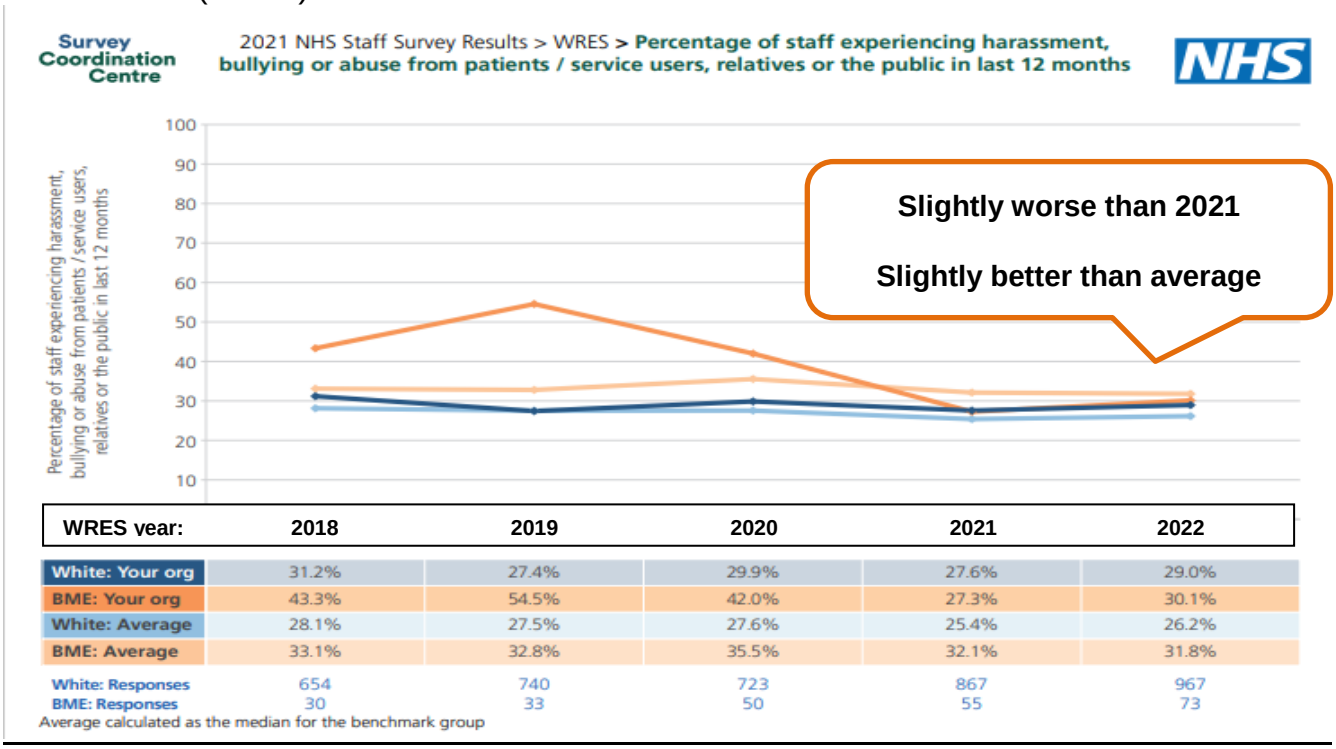
Indicators 5-8 Staff Survey Data Questions.

The data for the next four indicators is taken from Trust results in the 2021 NHS Staff Survey (displayed as 2022 for the purposes of WRES below).

Indicator 5: Harassment, bullying and abuse from patients
% of staff experiencing from patients, relatives or the public in the last twelve months

In 2022, we saw:-

- **An increase (2.8 % points)** in ethnic diverse staff experiencing harassment, bullying and abuse **(HBA) from service users and the public** (from 27.3% in 2021) to **30.1% in 2022**, and
  - That's **marginally worse** than the score for our white staff (1.4 % points difference), and
  - **Marginally better** (0.7 % points) than average for BME staff in our comparator MH Trusts (31.8%)



WRES year:	2018	2019	2020	2021	2022
White: Your org	31.2%	27.4%	29.9%	27.6%	29.0%
BME: Your org	43.3%	54.5%	42.0%	27.3%	30.1%
White: Average	28.1%	27.5%	27.6%	25.4%	26.2%
BME: Average	33.1%	32.8%	35.5%	32.1%	31.8%
White: Responses	654	740	723	867	967
BME: Responses	30	33	50	55	73

Average calculated as the median for the benchmark group

Figure 22

There has been a slight increase in HBA from service users and the public for both white and BME staff in the last reporting period. Levels are slightly higher than the comparator group (similar trusts) overall for white staff, but slightly lower than the comparator group for BME staff. Levels of HBA towards BME staff have generally fallen over the period since 2018.

We continue to encourage a high reporting rate for HBA incidents and our Clinical Risk Manager reviews each case individually and offers support to affected individuals. We have continued to advance our Inclusion Council project on Reducing and Responding to Personal Abuse Incidents with a staff engagement approach. We are currently in the process of developing a future project as part of our Inclusion Council which will focus on strengthening our culture of Civility, embedding wider work on Restorative Just and Learning Culture, and our approach to the NHS Violence Prevention and Reduction Standard Programme.

Indicator 6: Harassment, bullying and abuse from staff
% of staff experiencing harassment bullying and abuse from staff

In 2022, we saw significant worsening (9.7 % points) in the measure of BME colleagues experiencing HBA from staff

- **Up (worse)** from 16.7% **to 23.3%** (whilst there has been a fall in HBA to white staff)
- BME rate is **significantly worse** than it is for white staff (9.7% points difference)
- Marginally worse (by 0.4% points) than average for BME staff in comparator Trusts (22.9%)
- The BME rate is **similar** to that in 2019 and 2020 and significantly lower (better) than that in 2018.

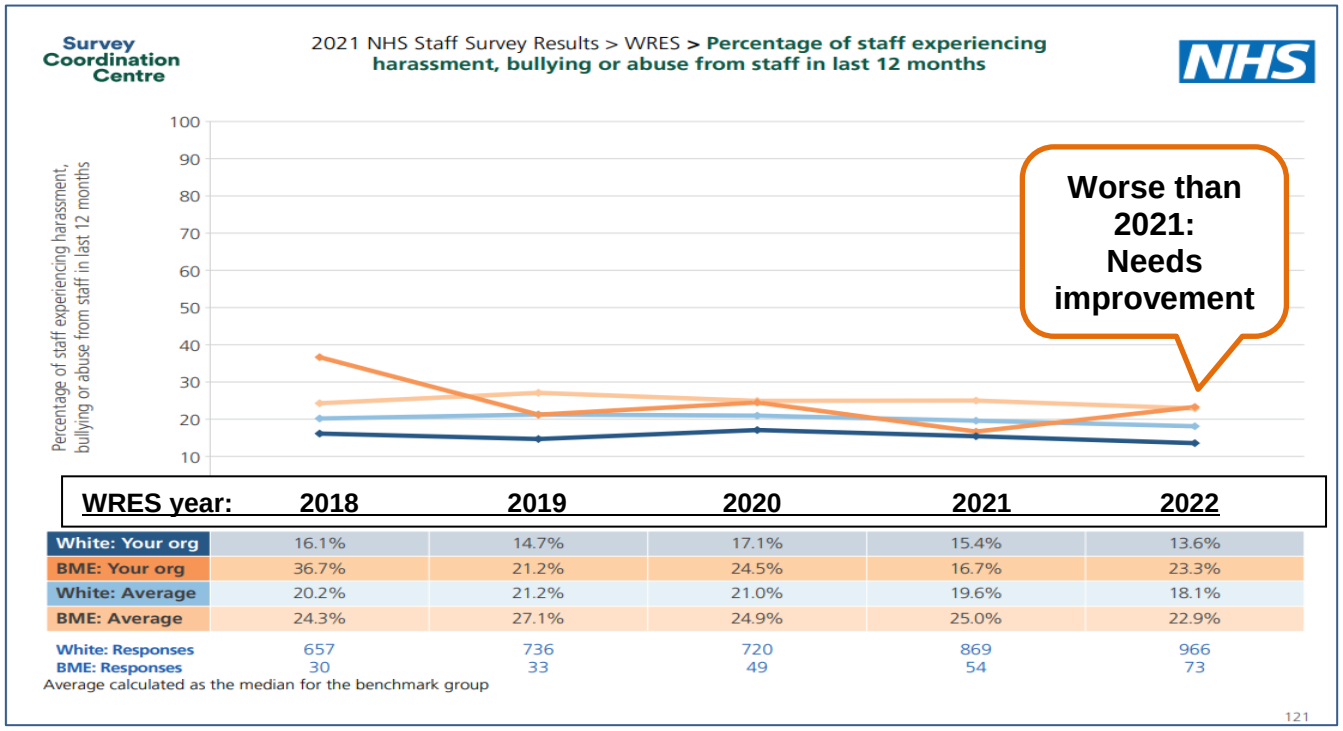


Figure 23

As outlined above in Indicator 5, we continue to encourage staff to report incidents of racial abuse and bullying of all kinds.

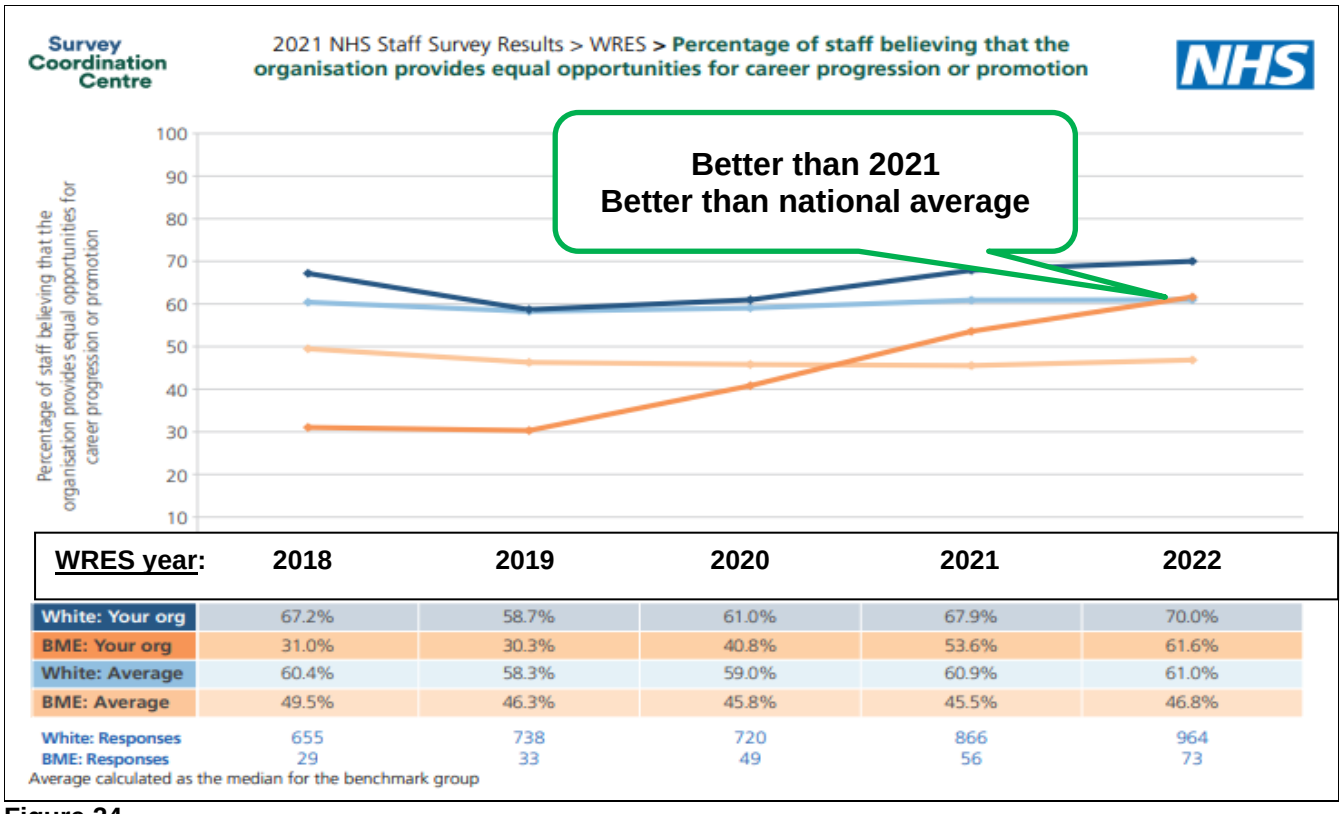
We continue to promote our Freedom to Speak Up access routes, in addition to the usual employee relations processes for raising of such concerns.

Indicator 7 - Belief in Equal Opportunities (EO)
% of staff who believe the Trust offers EO for career progression and promotion*

[Note: *It is noted that the NHS staff survey and WRES teams nationally have re-calculated this measure retrospectively. Data in this report reflects the revised data as issued in the trusts 2021 NHS staff survey Benchmark Report. Hence comparison on this measure with last years' WRES report will not be possible except through analysis of the historical data provided in this report.]

This measure shows an **improvement for second year in a row** in BME staff reporting equal opportunities for progression and promotion

- Up (Better) to 61.6% from 53.6% in 2021, and up from 40.8% in 2020)
- Significantly better (14.8 % points) than average for our comparator Trusts (46.8%)
- However, rate is lower than for Trust white staff (by 8.4% points)



WRES year:	2018	2019	2020	2021	2022
White: Your org	67.2%	58.7%	61.0%	67.9%	70.0%
BME: Your org	31.0%	30.3%	40.8%	53.6%	61.6%
White: Average	60.4%	58.3%	59.0%	60.9%	61.0%
BME: Average	49.5%	46.3%	45.8%	45.5%	46.8%
White: Responses	655	738	720	866	964
BME: Responses	29	33	49	56	73

Average calculated as the median for the benchmark group

Figure 24

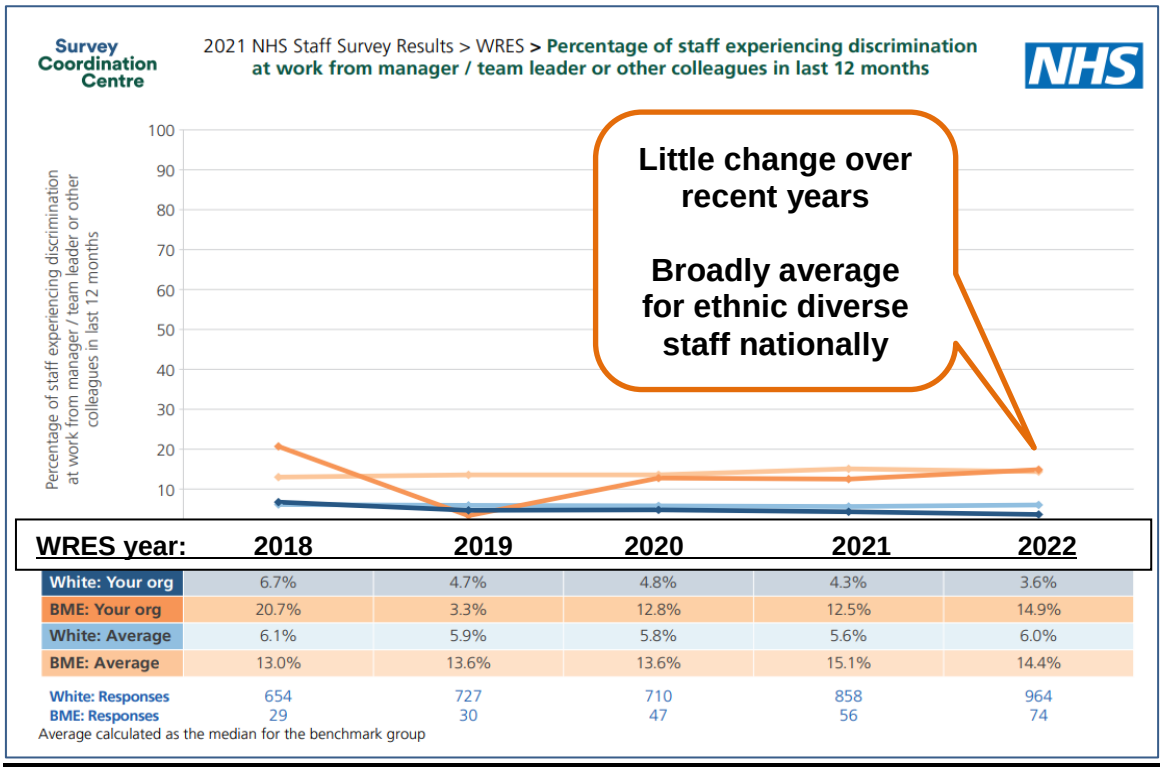
Our scores on belief in equal opportunities have improved for both white and BME staff, but much more significantly for BME staff. The BME rate has steadily improved since 2018. Whilst the gap has narrowed, there is unfortunately a remaining difference in the perceptions of BME and white staff of approximately 8 percentage points (white perceptions better than BME).

It is noted that over the last 2 years, the Trust score for both white and BME staff belief in equal opportunities is above the national average for MH trusts, significantly so for BME colleagues and this is testament to our work in this area and our improving culture of race equality and inclusion.

Indicator 8 - Experience of discrimination at work in the last 12 months

In 2022, we **marginally improved our position** on BME staff reporting discrimination by their manager or team leader (12.5% in 2019).

- Steady performance since 2020 and **substantial progress** (reduction) since our 2018 rate (which was 20.7% of BME staff)
- 2019 rate appears to have been an outlier with its low score on this measure
- **Continuing large gap** in experience between ethnic diverse and white staff (over 11 percentage points in 2022)



WRES year:	2018	2019	2020	2021	2022
White: Your org	6.7%	4.7%	4.8%	4.3%	3.6%
BME: Your org	20.7%	3.3%	12.8%	12.5%	14.9%
White: Average	6.1%	5.9%	5.8%	5.6%	6.0%
BME: Average	13.0%	13.6%	13.6%	15.1%	14.4%
White: Responses	654	727	710	858	964
BME: Responses	29	30	47	56	74

Average calculated as the median for the benchmark group

Figure 25

Staff survey reports of experience of discrimination by manager / team leader or other colleagues in the Trust have decreased slightly for white staff but increased slightly for staff with ethnic diverse identity, meaning the gap between the two is a little wider than in the previous year. However, the Trust score for ethnic diverse colleagues remains broadly average for MH Trusts**.**

As an outstanding Trust, we will seek to ensure a positive working environment and working relationships which enable all individuals to perform to their best. We will continue to work to create a culture in which all colleagues feel supported equitably and in which race discrimination is stamped out.

We will continue to work to close the gap on experiences of discrimination for staff who identify as having BME heritage and those who don't. Key to this is our culture of inclusion development and education approach (especially leadership education and development), as well as developing our civility and respect programme and our Restorative Just and Learning Culture approach.

Indicator 9
Trust BME Board membership

2022	White headcount	BME headcount	White %	BME %
Executive Directors	**5**	**3**	**62.5%**	**37.5%**
.. Of which: Voting members	**3**	**1**	**75%**	**25%**
Non-Executive	**7**	**none**	**100%**	**none**
..Of which: Voting members	**6**	**none**	**100%**	**none**
Total board members	**12**	**3**	**80%**	**20%**

Table 26

Good executive and overall representation. Non-Exec representation needs action / improvement as opportunity (vacancy) arises

[NOTE: The above 2022 data includes Peter Axon, substantive Chief Executive who is seconded presently to the local integrated care board (ICB). It does not include 3 associate director roles who support the board, as they are not employed by the Trust directly. This covers the roles of a Non-Executive HEI, Associate NED primary care and Associate director for governance and trust board (who is employed by the trust but not for WRES purpose as a board member).]

BME board headcount remains the same at 3 members (Percentage slightly reduced based on people in post on reporting date)

Indicator 9		2016	2017	2018	2019	2020	2021	2022
BME board member-ship	National WRES report	7.1%	7.0%	7.4%	8.4%	10%	12.6%	***To be published Feb 2023***
	NSCHT performance	**7.7%** ***Better than average***	**7.7%** ***Better than average***	**15.4%** ***Better than average***	**14.3%** ***Better than average***	**23.1%** ***Better than average***	**21.4%** ***Better than average***	**20.0%**

Table 27

The Trust continues to perform very strongly on this measure on ethnic diverse representation at Board level compared to our local population, consisting of 3 BME Executives. Our 2011 census footprint is only 7.6% ethnic diverse heritage, meaning the board very significantly over-represents. It is also noted that our Board membership as at 31 March 2022 includes female and male black representation, and female Asian (Bangladeshi) representation. It is noted and of concern, however, that currently we do not have any NEDs of BME identity. This is very important in a group making decisions and assuring quality of health service provision on behalf of a diverse population.

It remains an area for improvement when a vacancy arises in our NED structure to achieve more diverse representation. Any forthcoming NED recruitment will need to have a strong positive action approach to advertising the vacancy and reaching and appealing to an appropriate ethnic diverse audience. The selection process will need to be managed carefully to ensure a diverse shortlist and to seek to eliminate bias in the process. A positive action approach to decision making may be appropriate in the event that the leading white and leading ethnic diverse candidates should score equally.

The Trust's Board members (both with and without ethnic diverse heritage identity) have demonstrated their outstanding passion for inclusion and many have participated actively in internal and external events discussing race and wider inclusion over the past 12-18 months.

3.0 What has the Trust been doing to advance the WRES in 2021-22?

Working to advance diversity and inclusion has continued to be a high priority for the Trust throughout the second year of Covid, despite the many and severe operational challenges the pandemic has imposed on our health and care systems and services. We have not relented in our pursuit of a more equitable and inclusive organisation, system and society, taking a high-profile and multifaceted approach as outlined below.

We are extremely proud to have been recognised for excellence in our approach to growing workforce diversity and inclusion throughout this period, being credited with the following national awards received during 2021-22. These awards recognise our unique approach and absolute commitment to the inclusion agenda:

- *Winner of the HPMA Mills and Reeve Award for Leading In Equality, Diversity and Inclusion 2021*
- *Finalist in the HSJ Staff Engagement Award 2021*
- *Finalist in the HSJ Workforce Race Equality Award 2020 (awarded March 2021)*

<u>Inclusion Council</u>
The Trust's Inclusion Council has met consistently to discuss and develop performance on Inclusion with both a workforce and service user focus. Chaired by the Chief Executive, Deputised by the Director of People and with a diverse and representative membership, Inclusion Council has led 4 Inclusion Projects (Inclusive Recruitment, Inclusive Development, Responding to Incidents of Personal Abuse, and Culture of Inclusion). These projects reported their latest progress in July 2022 and are under review at the time of writing for the period going forward.

<u>Inclusive Recruitment and Development</u>
The Trust has continued to develop and deliver 2 projects focussed on delivering more inclusive recruitment and career progression outcomes, under the supervision of our Inclusion Council. The Trust requires that all selection processes for posts at band 7 and above have diverse selection panels including ethnic diverse representation. The standard approach for band 3 Healthcare Support Workers and band 5 Staff Nurses in the Trust is through assessment centres. These assessment centres reduce bias in decision making and are also supported by diverse panels. All recruiting managers receive training in inclusive recruitment. Our Inclusive Recruitment Guardians also receive special training in inclusive recruitment and how to be an effective panel participant.

In 2021-22 this has also led into system working on Inclusive Recruitment as part of the Workforce Race Equality and Inclusion Strategy (WREI).

<u>Inclusion School</u>
A key element of our approach to advancing workplace Inclusion, including race inclusion, is the delivery of our Inclusion Schools programme on behalf of Staffordshire and Stoke-on-Trent Integrated Care System. Inclusion School aims to influence and change behaviours through a 'show not tell' approach, based on powerful personal stories and conversation. Our first Inclusion School session was focussed on race inclusion, 'Let's Talk About Race'. All our Inclusion Schools take a wider and intersectional approach to inclusion. Our Inclusion School journey continues into 2022-23.

Comfortable Being Uncomfortable With Race and Difference

Our *'Comfortable Being Uncomfortable with Race'* cultural education programme is also led by the Trust on behalf of the system and is designed to create genuine culture change by challenging institutional and individual biases and micro-aggressions and incivility, encouraging leaders to have challenging conversations on race. This powerful approach to educating on racism and race Inclusion uses immersive, drama-based, interactive learning to place participants in a range of uncomfortable scenarios, based on real life events in the NHS.

New Futures and Stepping Up

The Trust has led on delivering a fourth local positive action development programme for aspirant leaders with ethnic diverse heritage from across the system, now known as 'New Futures'. *'New Futures'* works with an external provider with a track record of delivery on this type of learning to deliver a 5-day programme to 40 individuals (34 places accepted). The core programme (Feb to May 2022) is supplemented with a range of additional development offers, all geared at supporting participants to be 'ready now' when progression opportunities arise. All participants will become part of our *'Stepping Up' alumni* and, as such will receive access to information and development opportunities over the years to come, as well as tracking of their onwards development and career progression.

Other Leadership Development

- **High Potential Scheme** – the Trust is leading on the delivery of the HPS pilot (now in its second wave of recruitment) for aspirant NHS directors. Inclusion has been built in by design through this programme at every stage.

- **Connects leadership programme** – as with the HPS, inclusion is built in by design through this local leadership development programme for junior - middle managers

- **Developing Aspirant Leaders** - The Trust was delighted to have been awarded the system place on the Midlands Region NHS (positive action on race) Developing Aspirant Leaders programme in 2021-22. We are delighted to have been awarded 2 places on the 2022-23 cohort.

Staff Networks

The Trust has worked to further embed and increase the impact of our ENRICH Network in 2021-22. We are delighted that from April 2022, we have been able to award 2 days per month of dedicated time to our ENRICH lead for Network planning, delivery and other related activity. Our ENRICH lead and members are also encouraged to support our system ENRICH network. Our Trust Director of People, OD and Inclusion, Shajeda Ahmed, has actively supported the Trust and system ENRICH as executive sponsor (until leaving the Trust for career advancement in September 2022).

Freedom to Speak Up (FTSU) Approach

The Freedom to Speak Up Review (2015), considered the speaking up culture in the NHS in England and identified groups that faced barriers to speaking up. This included black and minority ethnic workers, trainees, locums and agency workers. We work in partnership with our Freedom to Speak Up (FTSU) Guardian whose role includes seeking to identify groups potentially facing barriers to speaking up and working to address those barriers.

The Trust has been actively seeking to recruit FTSU Champions from across different protected characteristics and professional disciplines. We are highly encouraged at the level of take-up across these groups, including a number of people of colour.

Of the 36 concerns reported in 2020/2021, 3 concerns were reported to be racially-driven.

4.0 ACTION PLANNED FOR 2022-2023

1. Strong, visible & personal Trust Board and senior leadership on race inclusion (Inds 1,7,8)

2. Commence our journey and development of supporting actions to deliver our accreditation against '**The Race Code' and as an anti-racist organisation**: (Inds 1,7 & 8)

   The Trust has recently signed up to The Race Code, with its 4 principles as below:-

   i. **Reporting** - Openness and transparency to create the right environment for change.
   ii. **Action** - A list of the measurable actions and outcomes that contribute to, and enable sustainable change in race equity and equality.
   iii. **Composition -** A set of key indicators that create tangible differences in race diversity representation across all levels of the organisation.
   iv. **Education** - Developing the ethical, moral, social, and business reasoning through which perspectives and prejudices will need to be challenged, and systemic and institutional practices acknowledged.

   The first meeting of the Trust's Race Code Steering Group took place on 14.9.22.

3. Consider '**See Me First' NHS Race Badge** scheme – currently being explored (Inds 5 & 6)

4. Continuing **Inclusion School** journey, including further race-focussed sessions to run in 2022/23 (Inds 1, 2, 7 & 8)

5. Continue to develop and embed the role and impact of our **Trust staff networks** (specifically ENRICH) as well supporting and contributing to the development of our system level networks (Inds 1, 2 & 7)

6. Continue the role of the **Inclusion Council**. Complete review and refresh of Inclusion Council projects for 2023 (inclg Culture of Civility & Respect and Inclusive Recruitment projects) (Inds 1, 2, 3 & 7)

7. Continue our **High Potential Scheme**, supporting the development of a diverse cohort of aspirant senior leaders through the first 2 cohorts of this flag-ship programme (Inds 1 & 2)

8. Continue to support and track progress of **New Futures & Stepping Up alumni**, exploring the possibility of a further cohort in 2022-23 (Ind 1 & 2)

9. Continue **promoting development opportunities**, coaching and mentoring, talent management and support, with specifically focus on those with ethnic diverse heritage (I.4)

10. Deliver second cohort of **Reverse / Reciprocal Mentoring** including race as a key characteristic for reverse mentors (Inds 1, 7 & 8)

11. Extending the focus on the **appointment, retention and advancement** of people of colour at every level, including student, bank, preceptor and substantive roles and developing the talent pipeline at every step through optimising use of apprenticeships and new roles (such as Nursing Associate roles). (Inds 1, 2 & 9)

12. Develop core action on the WRES in conjunction with system partners as a local Integrated Care Board. (As applicable)

(Note: many of the above actions are anticipated to have impact across the full range of WRES indicators)

5.0 Conclusions and Recommendations

A recent independent article (Adebowale, 2022 – see Appendix 2) stressed the need for deep-seated cultural change in the NHS on race inclusion, essential to avoid putting patients and staff who are people of colour at risk.

The need to develop greater race inclusion and equality continue to remain both an immediate and a long-term challenge. Our people need a compassionate and inclusive culture, an organisation where all colleagues feel looked after, valued and have a sense of belonging.

The Trust has made significant strides to progress our inclusion – and specifically our race inclusion - agenda during a most challenging period over the past few years. However, collectively as individuals, as an organisation and working as a system we need to continue our journey with passion and impact to address the societal, historical, cultural and organisational factors which culminate in our ethnic diverse workforce (and service users) continuing to experience poorer employment prospects and experiences than their white counterparts in the NHS on a range of indicators.

The Trust has made very significant strides in 2021-22 to keep the development of greater race inclusion as a high priority and in delivering tangible and substantial improvements in our WRES measures. It is incumbent that we continue to press forward with this agenda at every level of the organisation and across our Integrated Care System (ICS) and Board (ICB) for Staffordshire and Stoke on Trent.

We have been building on and educating for our culture of inclusion as a Trust and leading on much of this work on behalf of our system. Specifically, our Inclusion School approach, our Comfortable Being Uncomfortable programme, our New Futures programme and Stepping up Alumni, our High Potential Scheme approach and our Connects leadership programme. Many of these will continue in 2022-2023.

We have also recently commenced work on The Race Code and to develop a detailed and evidence-based Trust and system action plan around this in 2022-23.

Our work on developing workforce race inclusion over the past 2 years has gained regional and national recognition and much of this work is summarised above in this report. The further advancement that we are committed to implementing in 2021-22 will take us to the next stage in our ambition of delivering outstanding inclusion.

Board members, the Trust Senior Leadership Team (SLT) and members of the People and Culture Development (PCD) Committee are asked to:-

1. Note the progress with our 2021-22 WRES actions and journey

2. Approve this 2022 WRES report and Action Plans for 2022-23 for publication with the WRES Team, on the Trust's website and sharing with our lead commissioners

3. Continue to act as active ambassadors of race inclusion and to champion an inclusive and anti-racist culture for the ongoing development of tangible and measurable change on race equality and inclusion.

END

APPENDIX 1

NSCHT WRES ACTION PLAN 2021-22 Progress Report

WRES ACTION PRIORITIES 2021-22	**Relates to WRES Indicator(s)**	**Comments / progress to date**	**Where reported/ monitored**
Action 1 ***Continue to develop the Trust and wider system culture of inclusion to increase the inclusion awareness and inclusive behaviours of staff at all levels, and importantly those in leadership positions*** 1.1 Inclusion built-in to the design of all Trust/ system leadership programmes 1.2 Delivery of wider Trust and system roll-out of *Comfortable Being Uncomfortable with Race and Difference* programme 1.3 Delivery of Autumn Inclusion School (20 October and develop ongoing Inclusion School ambitions 1.4 Trust / system events to mark Black History Month and South Asian History Monty 1.5 Regular awareness raising communications on race inclusion and equality related matters through Trust internal and external communications and social media	Indicators 1-9	**ACHIEVED** **1.1 COMPLETED:** Inclusion is at the core of our trust and system leadership programmes including New Futures, System Connects and cohorts 1 and 2 of our High Potential Scheme. **1.2 COMPLETED:** 33 trust employees completed our *Comfortable Being Uncomfortable with Race and Difference* programme for 2020-2021, including 6 board members. Further rollouts are planned for 2022-2023 **1.3 COMPLETED**: 65 staff members participated in the summer and autumn inclusion schools. Future inclusion schools will be in our system plans. **1.4 COMPLETED:** These events were marked by a range of related development opportunities were shared and trust colleagues were encouraged to participate. Activities were predominantly on-line due to the Covid pandemic. **1.5 COMPLETED**: Weekly communications on inclusion through a variety of media: newsround, social media, team brief, all staff emails, and staff networks/Enrich members, staff network notice boards, wellbeing boxes issued to teams and towards the end of the financial year with the introduction of combined TV.	**Inclusion Council** **PCDC**

WRES ACTION PRIORITIES 2021-22	**Relates to WRES Indicator(s)**	**Comments / progress to date**	**Where reported/ monitored**
Action 2 ***Delivery against the High Impact Action Plan on Recruitment as part of the Midlands Workforce Race, Equality and Inclusion (WREI) Strategy*** Ensure specific focus on disability and neurodiversity is built in through all action areas of this plan Develop our trust pool of NHS ambassadors engaging directly with local communities and particularly with young people to build interest in the many different roles and professions in healthcare, ensuring the NHS represents the community it serves. Being integral in supporting those first steps in developing a talent pool for the future workforce.	Indicator 2	**2.0 ACHIEVED & ONGOING**: o Assessment centres now in place for Band 5 Registered posts, HCSW and apprenticeships o Advertising campaign created with inclusive imagery and wording with Nursing Times and BMJ o Initial discussions with staff network groups for inclusive recruitment material o Building on success of Nursing Times event and contacting areas outside of Staffordshire to encourage applications with relocation packages o Offering flexible shift patterns to attract wider range of applicants o International Recruitment to commencing in partnership with ICS o Values Based Development group commenced to look at recruitment o In depth review of Trac, how better to use it to suit the Trust and how to adapt application process for applications o Plans to increase Apprentice placements in 22/23 o Partnering with schools and colleges to create career events and open days to raise awareness of the variety of roles in the NHS o Promotion of advertising and campaigning for vacancies to include Staff Survey results o Collaborating with government funded bodies to promote careers in NHS for those that are currently unemployed or looking for a second career. o Talent Pool creation for unsuccessful applicants – succession planning and development o Re-designing our job adverts and job descriptions to be more attractive and inclusive o Review of current essential criteria for certain roles to remove unnecessary barriers to applicants.	Inclusion Council System People Board

WRES ACTION PRIORITIES 2021-22	**Relates to WRES Indicator(s)**	**Comments / progress to date**	**Where reported/ monitored**
Action 3 ***Trust Directorates each to deliver an action supporting the progression of workforce race inclusion through their services***	various	**ACHIEVED**	Directorate Leadership Team Trust Senior Leadership Team (SLT)
Action 4 ***Specifically target BME staff in the Trust/system Reverse Mentoring cohort to be established from Autumn 2021***	various	**PENDING**: The Covid pandemic and capacity issues at NHS Leadership Academy caused delays. However**, t**he revised timescale to commence Autumn 2022 via the leadership academy is planned.	Inclusion Council System People Board
Action 5 ***Further progress the Trust's 4 Inclusion Council projects, with specific reference/focus on race:*** 1. Inclusive recruitment (also see action 2) 2. Inclusive development 3. Preventing and Responding to Personal Abuse 4. Culture of Inclusion (+ see action 1)	Indicators 1-9	**ACHIEVED** **See inclusion council project reports**	Inclusion Council

APPENDIX 2

The NHS has a racism problem – to deny this is putting both patients and staff at risk

Although it is important that the NHS retains its independence, we will not change deep-seated cultural problems without a clear demonstration of political will

The NHS has always struggled to relate to race, even while relying on BAME staff to provide the care the population depends on.

In the 1950s and 1960s my mother, a nurse for over 40 years who qualified in Nigeria, experienced racism at its most direct. One attack by a patient left her with a permanent neck injury. Racial abuse of staff was standard until the 1980s, rarely tackled by the NHS leadership or seen as something they needed to address or even acknowledge. Thankfully, my mum retired some years ago, but she can still remember her suffering alongside the other Black, Asian, and Minority Ethnic (BAME) nurses.

We are a nation that struggles to talk about race, to relate to it, or accept that it has played a significant part in the history of our country. It is therefore not surprising that our most beloved institution, the NHS, contains a microcosm of the same dynamic in its culture.

This matters to me because of my six years on the Board of NHS England, and role as the current chair of the largest representative body of health and care leaders in the UK. I also persuaded Sir Simon Stevens, the last CEO of the NHS, to fund the NHS Race & Health Observatory (RHO) as an independent body capable of holding a mirror up to the NHS, so that it could truly see its inaction on racial disparities.

The RHO's report in February this year detailed clear evidence of racial bias in the treatment of people from BAME communities in the NHS. It also discussed the lack of progress on improving treatment of NHS staff from BAME communities. A previous study by the NHS Workforce Race Equality Standard (WRES) found a failure to support BAME staff; to provide equitable access to career opportunities; to stamp out bullying and racist behaviours; and to provide appropriate cultures of care for BAME staff. All this had a direct impact on the quality of care for all patients, regardless of race.

The NHS requires greater scrutiny on such issues because it deals with matters of life and death. The disproportionate poor treatment of Black staff and Black patients in the NHS shows that though we may all pay for a service, if you are Black, you run the real risk of being treated badly.

The evidence for the most effective interventions that change racist cultures is pretty clear; the actions of leaders make the most difference to culture. If we want to ensure that the NHS is both value for money and value for all people, NHS leadership has to take responsibility for the culture they are paid to create and lead.

The fact that the Health and Care Act 2022 has imposed a statutory duty on the NHS to focus on reducing health inequalities is an important step forward, although it is disappointing that the Act did not specify racial inequality within this new framework. This legal duty is something that we must keep under review. If the Health and Care Act 2022 fails to make a difference in the next few years, we may need to take additional steps to clarify the legal responsibilities for NHS bodies to tackle racial inequality, within an overall drive to ensure that every part of our society has access to high quality health and care services.

Political leadership is also essential to changing and improving the NHS's culture. Although it is important that the NHS retains its independence, we will not change deep-seated cultural problems without a clear demonstration of political will. Ministers should be asked to give an annual statement on the efforts being made to combat racial discrimination and inequality within the NHS. This political pressure will force leaders in the NHS to keep working on this agenda.

But words alone will not be enough and inaction needs to have consequences. In the NHS, one of the central motivators for change is money. We are now building the infrastructure to enable the NHS to collect consistent data on race. NHS bodies that consistently fail to make progress in tackling racial discrimination within their organisations should face financial penalties. An example could be looking at pay awards for senior leaders within the organisation. People who want the pay that comes with leadership roles need to demonstrate leadership on race.

Some may say that this is extreme, but racial discrimination has very real financial consequences for our country; from the loss of healthy working years, to poor access and diagnosis creating demand for more expensive acute interventions later down the track.

Leading all the people, all the time, everywhere, means making the undiscussable discussable. It means talking about race, racism, and inequality as though it matters to them, whether the leader in question is Black or white.

Lord Adebowale (2022) CBE is the chair of the NHS Confederation and the chair of Social Enterprise UK. This piece is an edited version of his essay in the new collection An agenda for action: New approaches to tackling racism and racial inequality in Britain, edited by Bright Blue and British Future

The NHS has a racism problem article